AMENDED IN SENATE APRIL 11, 2016

SENATE BILL No. 1098

Introduced by Senator Cannella

February 17, 2016

An act to ~~amend Section 14089 of~~ *add Section 14005.273 to* the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 1098, as amended, Cannella. Medi-Cal: ~~geographic managed care.~~ *dental services: advisory group.*

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law ~~authorizes the department to provide health care services to beneficiaries through various models of managed care, including through a comprehensive program of managed health care plan services for Medi-Cal recipients residing in clearly defined geographical areas. Existing law specifies guidelines the department is required to follow in selecting and entering into contracts with managed care plans. Existing law requires the department to give an eligible beneficiary specified notices for the purpose of assisting the beneficiary in choosing a managed care plan, and imposes requirements on the beneficiary and the department regarding choice of, and enrollment in, a managed care plan.~~ *provides coverage for certain dental services, as specified, to Medi-Cal beneficiaries 17 years of age and under through the Denti-Cal program.*

This bill would ~~make technical, nonsubstantive changes to those provisions.~~ *establish the Denti-Cal Advisory Group in the department,*

as specified, for the purpose of studying and overseeing the policies and priorities of Denti-Cal with the goal of raising the Denti-Cal utilization rate among children and providing assistance and advice to the department, the Governor, and the Legislature to ensure that proposed decisions relating to the Denti-Cal program are based on the best available evidence. The bill would make related legislative findings and declarations.

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Denti-Cal is the Medi-Cal dental health care component program that was established soon after the 1966 creation of the Medi-Cal program.

(2) According to an audit conducted by the State Auditor in 2014, only 43.9 percent of children enrolled in the Denti-Cal program had seen a dentist in the previous year—a utilization rate that was the 12th worst among states that submitted data to the federal Centers for Medicare and Medicaid Services. Eleven California counties had no Denti-Cal providers or no providers willing to accept new child patients covered by Denti-Cal.

(3) Denti-Cal's 13 million or more beneficiaries need the State Department of Health Care Services and dental care providers to improve their relationships.

(4) In any sector, public or private, good relationships are built on a foundation of good customer service.

(b) Therefore, the Legislature establishes pursuant to this act an evidence-based advisory group to guide Denti-Cal priorities, to oversee policy decisions, and to increase annual Denti-Cal utilization rates among children in the state to 60 percent or greater, as is the case in approximately 20 percent of states.

SEC. 2. Section 14005.273 is added to the Welfare and Institutions Code, to read:

14005.273. (a) There is hereby established in the department the Denti-Cal Advisory Group. The duties of the advisory group shall include, but not be limited to, all of the following:

(1) Studying and overseeing the policies and priorities of Denti-Cal, the state Medi-Cal dental services program, with the goal of raising the Denti-Cal utilization rate among eligible child beneficiaries to 60 percent or greater.

(2) Providing assistance and advice to the department, the Legislature, and the Governor regarding proposed decisions relating to the Denti-Cal program to ensure that those decisions are based on the best available evidence.

(b) The advisory group shall consist of the following members:

(1) The state dental director, who shall serve as its chair.

(2) Eight members appointed by the Governor that shall include the following:

(A) A representative from the California Dental Association.

(B) A representative from the California Dental Hygienists' Association.

(C) A licensed social worker.

(D) A representative of a health care foundation.

(E) A licensed pediatrician who is qualified to assess impacts on the overall health of children.

(F) An expert on practices in the dental insurance or health insurance markets.

(G) Two university professors who are experts in dental practice or the dental services field.

(3) Two members appointed by the Senate Committee on Rules that shall include the following:

(A) A licensed dentist.

(B) A licensed dental hygienist.

(4) Two members appointed by the Speaker of the Assembly that shall include the following:

(A) A licensed dentist.

(B) A licensed dental hygienist.

(c) Before entering upon the discharge of his or her official duties, each member of the advisory group appointed pursuant to this section shall take and file an oath pursuant to Sections 1360 and 1363 of the Government Code.

(d) A member of the commission shall serve for a term of three years. There shall be no limit on the number of terms a member may serve. The terms of members may be staggered so that the terms of all members will not expire at the same time.

(e) A member of the advisory group shall not be compensated for his or her services, except that he or she shall be paid reasonable per diem and reimbursement of reasonable expenses for attending meetings and discharging other official responsibilities as authorized by the department and this section.

~~SECTION 1. Section 14089 of the Welfare and Institutions Code is amended to read:~~

~~14089. (a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in clearly defined geographical areas. It is further the purpose of this article to create maximum accessibility to health care services by permitting Medi-Cal recipients the option of choosing from among two or more managed health care plans or fee-for-service managed case arrangements, including, but not limited to, health maintenance organizations, prepaid health plans, and primary care case management plans. Independent practice associations, health insurance carriers, private foundations, and university medical centers systems, not-for-profit clinics, and other primary care providers, may be offered as choices to Medi-Cal recipients under this article if they are organized and operated as managed care plans, for the provision of preventive managed health care plan services.~~

~~(b) The department may seek proposals and then shall enter into contracts based on relative costs, extent of coverage offered, quality of health services to be provided, financial stability of the health care plan or carrier, recipient access to services, cost-containment strategies, peer and community participation in quality control, emphasis on preventive and managed health care services and the ability of the health plan to meet all requirements for both of the following:~~

~~(1) Certification, where legally required, by the Director of the Department of Managed Health Care and the Insurance Commissioner.~~

~~(2) Compliance with all of the following:~~

~~(A) The health plan shall satisfy applicable state and federal legal requirements for participation as a Medi-Cal managed care contractor.~~

~~(B) The health plan shall meet standards established by the department for the implementation of this article.~~

~~(C) The health plan receives the approval of the department to participate in the pilot project under this article.~~

~~(c) (1) (A) The proposals shall be for the provision of preventive and managed health care services to specified eligible populations on a capitated, prepaid, or postpayment basis.~~

~~(B) Enrollment in a Medi-Cal managed health care plan under this article shall be voluntary for beneficiaries eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).~~

~~(2) The cost of each program established under this section shall not exceed the total amount that the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.~~

~~(d) (1) An eligible beneficiary shall be entitled to enroll in any health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides. The department shall make available to recipients information summarizing the benefits and limitations of each health care plan available pursuant to this section in the geographic area in which the recipient resides. A Medi-Cal or CalWORKs applicant or beneficiary shall be informed of the health care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.~~

~~(2) No later than 30 days following the date a Medi-Cal or CalWORKs recipient is informed of the health care options described in paragraph (1), the recipient shall indicate his or her choice, in writing, of one of the available health care plans and his or her choice of primary care provider or clinic contracting with the selected health care plan. Notwithstanding the 30-day deadline set forth in this paragraph, if a beneficiary requests a directory for the entire service area within 30 days of the date of receiving an enrollment form, the deadline for choosing a plan shall be extended an additional 30 days from the date of that request.~~

~~(3) The health care options information described in this subdivision shall include the following elements:~~

~~(A) Each beneficiary or eligible applicant shall be provided, at a minimum, with the name, address, telephone number, and specialty, if any, of each primary care provider, by specialty or~~

~~clinic participating in each managed health care plan option through a personalized provider directory for that beneficiary or applicant. This information shall be presented under the geographic area designations by the name of the primary care provider and clinic, and shall be updated based on information electronically provided monthly by the health care plans to the department, setting forth changes in the health care plan provider network. The geographic areas shall be based on the applicant's residence address, the minor applicant's school address, the applicant's work address, or any other factor deemed appropriate by the department, in consultation with health plan representatives, legislative staff, and consumer stakeholders. In addition, directories of the entire service area, including, but not limited to, the name, address, and telephone number of each primary care provider and hospital, of all Geographic Managed Care health plan provider networks shall be made available to beneficiaries or applicants who request them from the health care options contractor. Each personalized provider directory shall include information regarding the availability of a directory of the entire service area, provide telephone numbers for the beneficiary to request a directory of the entire service area, and include a postage-paid mail card to send for a directory of the entire service area. The personalized provider directory shall be implemented as a pilot project in Sacramento County pursuant to this article, and in Los Angeles County (Two-Plan Model) pursuant to Article 2.7 (commencing with Section 14087.3). The content, form, and geographic areas used shall be determined by the department in consultation with a workgroup to include health plan representatives, legislative staff, and consumer stakeholders, with an emphasis on the inclusion of stakeholders from Los Angeles and Sacramento Counties. The personalized provider directories may include a section for each health plan. Prior to implementation of the pilot project, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine the parameters, methodology, and evaluation process of the pilot project. The pilot project shall thereafter be in effect for a minimum of two years. Following two years of operation as a pilot project in two counties, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine whether to implement personalized provider directories as a permanent program statewide. If~~

~~necessary, the pilot project shall continue beyond the initial two-year period until this determination is made. This pilot project shall only be implemented to the extent that it is budget neutral to the department.~~

~~(B) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the health plans available and has the available capacity and agrees to continue to treat that beneficiary or eligible applicant.~~

~~(C) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a health care plan.~~

~~(4) At the time the beneficiary or eligible applicant selects a health care plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected health care plan.~~

~~(5) Commencing with the implementation of a geographic managed care project in a designated county, a Medi-Cal or CalWORKs beneficiary who does not make a choice of health care plans in accordance with paragraph (2), shall be assigned to and enrolled in an appropriate health care plan providing service within the area in which the beneficiary resides.~~

~~(6) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select a primary care provider who is available, the health care plan selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.~~

~~(7) A Medi-Cal or CalWORKs beneficiary dissatisfied with the primary care provider or health care plan shall be allowed to select or be assigned to another primary care provider within the same health care plan. In addition, the beneficiary shall be allowed to select or be assigned to another health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.~~

~~(8) The department or its contractor shall notify a health care plan when it has been selected by or assigned to a beneficiary. The health care plan that has been selected or assigned by a beneficiary shall notify the primary care provider that has been selected or assigned. The health care plan shall also notify the beneficiary of the health care plan and primary care provider selected or assigned.~~

~~(9) This section shall be implemented in a manner consistent with any federal waiver that is required to be obtained by the department to implement this section.~~

~~(e) A participating county may include within the plan or plans providing coverage pursuant to this section, employees of county government, and others who reside in the geographic area and who depend upon county funds for all or part of their health care costs.~~

~~(f) Funds may be provided to prospective contractors to assist in the design, development, and installation of appropriate programs. The award of these funds shall be based on criteria established by the department.~~

~~(g) In implementing this article, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this subdivision may be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.~~

~~(h) Notwithstanding any other law, on and after the effective date of the act adding this subdivision, the department shall have exclusive authority to set the rates, terms, and conditions of geographic managed care contracts and contract amendments under this article. As of that date, all references to this article to the negotiator or to the California Medical Assistance Commission shall be deemed to mean the department.~~

~~(i) Notwithstanding subdivision (q) of Section 6254 of the Government Code, a contract or contract amendments executed by both parties after the effective date of the act adding this subdivision shall be considered a public record for purposes of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and shall be disclosed upon request. This subdivision includes~~

~~contracts that reveal the department's rates of payment for health care services, the rates themselves, and rate manuals.~~

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